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Feb.—March
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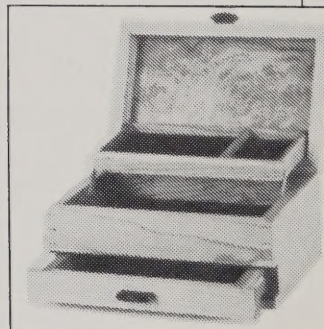
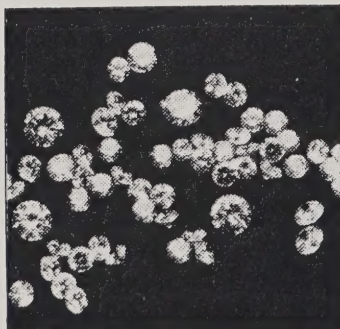
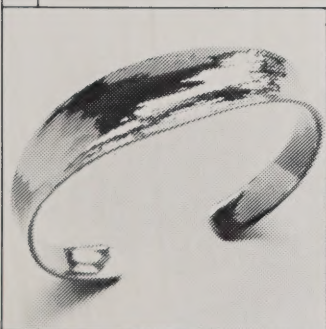
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**THE HAMPDEN HIPPOCRAT**

FEBRUARY-MARCH 1989
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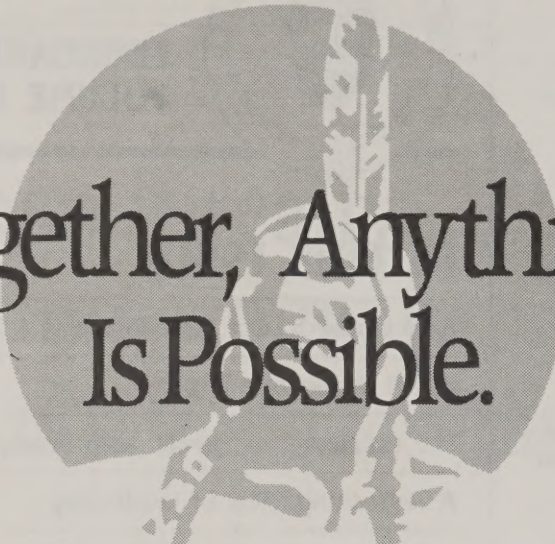
On our cover is Mercy Hospital in Springfield, Massachusetts. See related article on page 16 in this issue.

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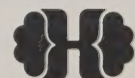
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A Welcome To Our New Readers

February, 1989, Volume XXXV, No. 1, The Hampden Hippocrat proudly and optimistically expands into a new era. With this issue our circulation expands to 1,700 physicians (approximately doubling our previous circulation) in Franklin, Hampshire, and Berkshire districts, as well as our Hampden District—thus, all of Western

Massachusetts. This expansion has been born of a desire to bring a unity, solidarity if you will, to the physicians of Western Massachusetts, nurtured by the recognition that we are missing the input of many fine minds in the other three districts; and spurred on by the strengthening of our financial base that increased circulation brings.

Volume I, No. 1 was published in 1942 in an era in which World War II rightly over-shadowed all other organizations and events. Editor-in-

Chief, E.P. Bagg, M.D. of Holyoke opened the initial volume with the following remarks.

"Greetings"

When paper and printer's ink for existing publishing needs, are becoming scarcer than neo-natal teeth why in the blue ethereal should anyone elect to thrust another

sheet upon the cluttered medical reading table? Heaven knows enough already goes unread to the salvage man. Only the increasing gravity of important problems which concern or threaten the very life of the medical profession can justify such a venture. We do not propose to compete with scientific journals for they are adequate. Nor do we promise you entertainment, (we would not sour you on Milquetoast, nor could we rival Bumstead at our balmiest). We undertake merely to prod your inattention; to keep you informed in brief upon movements such as the further encroachment of government into the field of medicine, and to offer a medium for your active discussion of vital issues. If there is found to be no such need, or you prefer a pre-Pearl Harbor paradise, then may our brazen leaflet die aborning. But in defense of its sponsors, let us cite the dictum of Euripides: "Try first thyself, and after call in God".

Volume I was a homey kind of newsletter, but the Hippocrat rapidly expanded into a publication with the efforts of Hampden physicians to effect the issues of their times and express their ideals, ideas, and frustrations. But, now in the latter part of the 20th century it is perhaps a time to become less parochial. Thus, we welcome our brothers and sisters of Berkshire, Franklin and Hampshire to our readership; we look forward to your participation and contributions and pray that this publication may be instrumental in improving the practice of medicine in Western Massachusetts.

Finally, we encourage all physicians and medical organizations of Western Massachusetts to use the Hampden Hippocrat to voice their ideas through formal articles or letters to the Editor. ■

The Editors



HDMS President's Message

Bits And Pieces



J. Gordon Rich, M.D., President

This article will be a potpourri, covering several areas of interest and concern. By the time this gets into print, we will have been through our January meeting, and a fund raiser will have been held for the beleaguered obstetricians. The physicians here need to be aware of the support given by the Massachusetts Medical Society on behalf of the obstetricians. Legal and general advice and help has been given, and Doctor O'Connor sent out a state-wide appeal for financial support, in addition to the local efforts being made. This has been most helpful, and made us feel that we are not alone in struggling with this problem.

The subject of a Resource Based Relative Value Scale

as a basis for physician payment under Medicare seems to be taking more definitive shape. Two or three years ago, Congress was thinking of controlling payments to physicians through a physicians DRG payment scheme, or through a fixed fee schedule. A third possibility was that of a relative value scale mechanism. You may recall that relative value scales enjoyed a period of interest in the early 1970's, but when put together by physicians were held to be in restraint of trade by the Justice Department and the Federal Trade Commission; and were abandoned in the face of government opposition and threat of legal action. Now the same concept is back, but under government sponsorship; what goes around comes around. The subject of a relative value scale also fit in with some of the internal politics of our profession, in that primary care physicians had long felt that they were underpaid in comparison with procedure-oriented practitioners. So, the AMA entered into a joint sponsorship, with the government, of a study to determine the feasibility of and structure that such a Value scale might take. Hence came the Harvard study now before the Physician Payment Review Commission. Taken all around, the relative value concept seemed less noxious than physician DRGs or a fixed fee schedule determined by government bureaucrats.

At the recent interim meeting of the AMA House of Delegates, and after a day-long debate, an unexpected degree of agreement in that body was achieved. The gist of the consensus arrived at is that a resource based RVS, with further study and modification, could provide the basis for physician reimbursement under medicare and medicaid. Clearly, the ball is rolling toward implementation of such a payment system. Meanwhile, the American College of Surgeons has distanced itself from the AMA involvement in all of this, and has an arm's length posture relative to the whole concept. Surgical
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leaders have expressed grave reservations about all of this, and the reasons aren't very hard to figure out: it is likely that the surgical ox is going to get gored, at least in some specialties. So, we can watch as all of this plays out over the next twelve months or so. With the government leading the way, the other third party payors won't be far behind on the relative value concept.

Another area is heating up at the federal level. The application of federal anti-trust laws to physician activities has generally been viewed as a legal grey area, but the federal justice department seems to be moving into a more activist position in this regard. Justice Department officials have recently stated that criminal charges will be leveled against competing physicians if they fix fees, allocate patient territories, or boycott insurers. Also, ignorance of antitrust law or belief that actions were undertaken to improve patient care will be no defense against criminal antitrust charges. To this end, the Department of Justice is moving against obstetricians in Savannah, Ga, allergists in Boston, and dentists in Tuscon, Arizona. We are starting to have some local experience with this sort of thing, as you are all aware. We are asking our state attorney general to address our spring meeting and take up the subject of antitrust law as it applies to physicians. I think this is an area about which most of us know very little, and probably need some information. I don't know if Mr. Shannon will respond favorably to our invitation, but I sincerely hope so.

Finally, let's take a look at some facts about our overall health care system. Overall health care costs are up 10% in 1988—again exceeding the rate of inflation—to \$548 billion per year. People are shifting the burden of this back and forth, but just about all of the health care players are having problems. Hospitals are having problems meeting expenses (most of the ones in this state are running deficits). Nursing homes are bleeding red ink. Insurance premiums were raised, but the insurance companies suffered underwriting losses of \$10 billion or more in 1988. Physicians are thought to have kept up, but raised their fees an average of 8 to 10% in order to do so. Insurance premium increases averaged about 20% but hit 60% in some cases. Nationwide, HMOs are having problems; some of the largest are restructuring and scaling back. Others are having problems living up to their promise to hold down costs, as their expenses rise. This turmoil is likely to keep health care up front as a top political priority at all levels of government. If these problems continue or increase in severity, there may well arise a general push on the part of the body politic for a total revamping of the health care system. We need to be aware of what is going on, the concerns that these factors raise, and try to be responsible and sensitive in our own activities—both professional and economic. On the subject of rising costs, our professional

liability "crisis" is hardly solved. As an orthopedic surgeon, I find that the number of orthopedists engaged in full surgical practice is shrinking, with the result that the remaining surgeons left are being hit with escalating bills for retro-active payments. For 1/3 million dollar coverage in 1988-89, the orthopedic tab is over \$60,000. Whereas we used to pay relatively low premiums by national standards, we have now forged into the upper ranks of high-premium states. With so many mandated caps on reimbursement, the cost-price bind is significant and getting worse. I cite my own situation, because it's the one I know best, but everybody else is in the same boat to a greater or lesser extent. Clearly, more "reform" in this disastrous liability system is needed. Get on the horn to your friendly neighborhood politicians. Well, here's to getting through another year, and maybe—just maybe—some good news may surface—but don't count on it...

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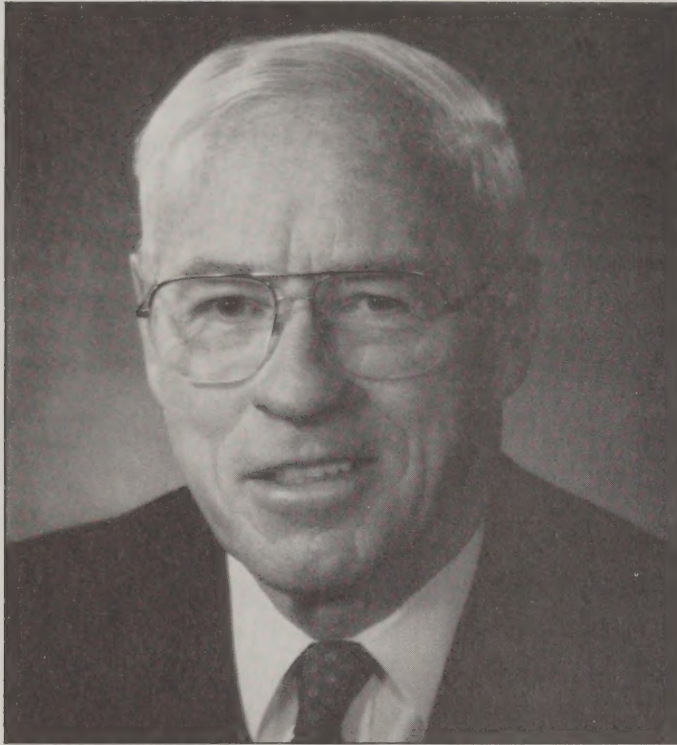
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The Challenge of Membership Services



Joseph J. O'Connor, M.D., President
Massachusetts Medical Society

People join professional organizations for many reasons. The most important reason, however, is what the organization can offer you. A professional association that can't answer the question "What have you done for me lately?" won't attract, or retain, members for long.

The Massachusetts Medical Society has to be accountable for that question to 14,000 physicians across Massachusetts, whether they are physicians preparing to retire, completing training, or in practice at the height of their medical careers. We are also accountable for the twin aspects of the Medical Society in facing the "challenge" of membership service.

First, the officers and staff of the MMS must build an internal operation that runs smoothly, spends members' dues wisely and cost effectively, reacts quickly to short-term crises, and plans ahead for long-term growth and activity. Second, the MMS must reach out externally, to the legislature, health-care organizations, regulatory agencies, and the general public to bring the physician's message to these groups. Lacking strong internal controls and foresight, the internal operations are wasteful and inefficient; without external outreach and cooperation the Society and its members exist in a vacuum.

The Society's officers are ultimately responsible for the success of these two missions, and in my year as MMS president I can point to some initial accomplishments and future plans in both areas.

The Society's Internal Organization

To be effective, and to place the Society on the road to the future, the organization, internally, must be proactive, not just reactive. The "ship of state" that is the Medical Society has definitely made some proactive changes in the last few years. Your leadership—myself, president-elect Bill Lavelle, and vice president Barry Manuel meet weekly to discuss activities, strategize on solving problems, and to think and plan ahead.

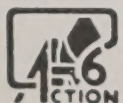
The recent reorganization of our Long-Range Planning Committee has been integral to our success, as well as the restructuring of other MMS committees. We are also looking toward further restructuring at MMS headquarters, using a long-term oversight committee that will ensure our organizational structure anticipates the changes ahead in Massachusetts medicine.

Restructuring our headquarters departments to meet the future needs of our members also positions us for the future. We have made several of those changes over the years: a revamped and staffed Department of Health Care Systems and Policy Analysis; stronger emphasis in

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member services and a continual search for even better services; and an acknowledgement that good physicians need good public relations, with a deepening commitment to telling the physician's story in Massachusetts.

Chief among our long-range plans, however, are the Society's finances. There are many things we need to bring us into the twenty-first century, but the fiscal ability and resources to carry out our activities must be a top priority. Although dues and nondues incomes are integral to daily operation of the Medical Society, it is the advertising revenue, from the *New England Journal of Medicine* on which we most depend at present. Any downward fluctuation of those revenues (not likely, given the *Journal's* preeminence, but a remote possibility that must be considered) would seriously jeopardize the Society's ability to carry on its business.

To plan for a financially healthy future, we formed the MMS Endowment Fund in 1987, designed to husband profits into a twenty-year fund that will serve as the Society's financial safety net. As structured, the Society is required to contribute to the Fund for twenty consecutive years without option to use the funds, and withdrawals from the Fund thereafter can be made only with approval of the MMS Council. We have also taken a more active role in recent years to oversee the *Journal's* finances, as we work to assure the *Journal's* continued prosperity.

The Society's External Activities

Today, physicians are deeply interwoven into the fabric of our health-care system. We are joined there by lawyers, state regulators, hospitals, ancillary care personnel, and the general public. Gone are the days when medicine existed as a truly independent profession. Physicians today practice medicine encumbered by regulation, besieged by a cost-earnings squeeze that grows worse each year, and under fire for anything less than a perfect result from every medical encounter.

The "face" we present to those outside medicine, then, is critically important to the future of our practices. We must project an image today of the physician as a caring professional.

The key is aggressive community relations work and coalition building—with hospitals, the elderly, advocates, lawyers, nurses. We have spent considerable time and effort in the past few years to building coalitions with the MHA, the elderly, alternative delivery systems (that now employ 40 percent of medical school graduates), nurses, medical schools, and others.

The public also has to be convinced, and need to know that the money and the time they spend for their medical care is well spent. They need to know that their doctors are well trained, and will provide the care that is needed. But most of all, people need to know that doctors care about patients' problems and want to help. I am convinced that we can best carry out that public relations campaign in our own offices, with strictly medical things such as AIDS, heart disease, the dangers of smoking,

etc. If we put across the messages that we can be our patients' source of information and that we truly care about them, they'll believe us. And our images—in their eyes and on the state level, will improve.

An important part of Society activities centers on anticipating and reacting to changes in medical practice on a national and state level. The peer review movement, like it or not, is here to stay. We realized this some years ago when we took steps to form a physician-based review organization. We understood the need that peer review must be structured so clinicians can continue to provide the very best of care to their patients without fear of censure.

MassPRO, our subsidiary that conducts Medicare peer review in Massachusetts, consistently emphasizes its mission as one that emphasizes the positive power of education, not the negative coercion of sanctions. MassPRO's president, Brenda Richardson, M.D., expressed this well recently at an AARP forum in Washington:

PROs must contribute to the search for better ways to define what quality *is*, so we can better establish what it *isn't*. However, we also need to develop ways to communicate better the result of our quality assurance review without breaching the confidentiality needed in the process. We need to tell Medicare beneficiaries and physicians not just the number of instances where the care is below standard, but when care *meets* (emphasis added) quality standards.

Unfortunately, regulations is a part of our lives. But physicians who take an active role in the regulation of medicine and become personally involved, fulfill their responsibility to work as patients' advocates.

And we must continue to be active on the subject of "cookbook" medicine, which has its share of proponents in the federal government. We can see part of that "cookbook" approach concerning Medicare part B reimbursement, as Dr. Hsiao's Resource-Based Relative Value Study (RBRVS) has become the hot topic in health-care cost containment. The Society is analyzing the RBRVS and will be working with the specialties and the AMA during 1989 as the battle begins to put some kind of RBRVS into place for Medicare. The "gurus" of health-care management who have actually served on the front lines of clinical medicine—in the operating room, the emergency room, CCU or ICU—are few indeed. But they have the power to mandate how we practice medicine. If physicians who are caring for patients in all clinical settings don't reclaim this power for ourselves, we shall see the attempts to improve the quality and effectiveness of medical care actually destroy patient benefits. That must not happen.

Concurrently, the Society's external activities have to be focused on the goal of keeping our wisest, most experienced physicians in practice while retaining our youngest and brightest clinicians-in-training. We have continued

The Challenge of Membership Service

continued from previous page

seen the financial bases for practice eroded by increased liability premiums and restrictive reimbursements. Our cost-earnings squeeze tightens each year. And our ranks thin at the very time people most need good physicians.

The crisis in malpractice insurance has consumed increasing amounts of Society labor and resources in the past few years and remains our top priority today. We work with a two-pronged strategy—continued aggressive representation of physicians at rate-making hearings, plus in-depth meetings and negotiations with the Joint Underwriting Association and the legislature. Without such advocacy in the 1970s and 1980s, (although the growing premiums have badly thinned our ranks), we would have paid millions upon millions in additional premiums that would have decimated medicine in Massachusetts. We are continuing to research hospital financing options for physicians' liability insurance burden.

The many hours we spend lobbying, attending legislative hearings, and submitting testimony to regulatory agencies certainly doesn't grab daily headlines. But this ongoing work helps us meet short-term goals while paving the way for work ahead.

Advocacy for Individual Physicians

Service to individual members can be defined as a kind of "external outreach," and is the foundation of any professional membership association. Although we do not have vast staff resources in headquarters, we do urge members to call us with questions or problems in legal matters relating to the medical practice, continuing medical education, third-party claim processing, reimbursements under state agency programs, etc. Many of you have received valuable assistance free of charge.

External advocacy for our members is never as important as when it concerns the plight of a few individuals, especially when that plight involves the inequities of medical practice in Massachusetts. This is the case concerning the "Springfield 24," those Springfield obstetricians who were charged in August 1988 by the Massachusetts Attorney General with "conspiring to boycott" Blue Shield.

We have advocated—and will continue to advocate—for these Springfield obstetricians to the very limits of the federal antitrust laws. We invited all the physicians named in the suit, and their counsel, to a meeting at MMS headquarters in September to identify and discuss the relevant antitrust and health-care legal issues in the case. The MMS legal department staff, with our outside

counsel, Choate Hall and Stewart, and AMA General Counsel Kirk Johnson, participated in the meeting.

Choate Hall and Stewart also provided technical advice to the Hampden District concerning formation of a legal defense fund for the "Springfield 24". We have publicized this fund statewide and urged all physicians to contribute. Choate Hall and our inhouse legal staff still respond to requests for information and clarifications from both the Hampden District and the individual physicians. Our Hampden District colleagues should be assured that we shall continue to assist them.

Part of quantifying the problems of access to care, problems that are becoming more acute, is to obtain an accurate picture of the delivery of medical services. This involves our long-term database project. In this project we plan to construct a Massachusetts-specific database using data from the AMA, our own membership records, and the Board of Registration in Medicine.

The MMS Department of Health Care Systems and Policy Analysis under Director Wil Lybrand is continuing work on this critical project. After the three databases are merged into one we plan to conduct at least one regular census of Massachusetts physicians. It is vital to our long-range planning to have a credible database, one that will give us an important tool to help illustrate the true picture of medical practice statewide.

We continue our meetings with the Board and hope to make further progress in the administrative law area. Our relationship with our primary regulator may never be a smooth one, but with a shared commitment to facilitating and maintaining the provision of quality medical care in Massachusetts, we can accomplish much together.

For the Future

With the tools we now have in place—a flexible, yet strong, management team, a renewed commitment to fiscal responsibility and long-term financial planning, increased emphasis on service (whether on the individual or district level) and dedication to building and improving the physician's image, we can meet that challenge of giving you, our members, the best value for your membership dollar. As I said in the beginning, we have a responsibility to answer your question of "What have you done for me lately?" every day. The Massachusetts physician, who is among the most respected and valuable members of the American medical profession, deserves no less. ■

Joseph J. O'Connor, M.D.

A Refreshing View of Leadership

(Excerpted with permission from Editorial by Herve Byron M.D., F.A.C.S.
Ophthalmology Management January 1989.)

At the Houston seminar of Future Focus, Henry Hirschman fortuitously gave me a copy of the *Windstar Journal*, a fascinating publication headed by John Denver and his foundation. Windstar is a catalyst for responsible action toward a sustainable future on a global scale. In this Autumn 1988 issue, an article titled "The Leaders We Need" by Kim McMillan fascinated me. Her content addressed this critical problem of leadership that ophthalmology faces. She sheds profound insight about this important yet nebulous subject of leadership. With the permission of the author and the publisher, I would like to share the entire article with you:

"I keep searching for real leaders. I am looking for leaders who know who they are and are willing to say for what they stand. I am looking for leaders who have values and priorities, and are passionate about them. I am seeking leaders who maintain an integrity between their words and deeds, leaders who reach out and speak up, leaders who are not afraid to make their mark.

We have not lost the ability to be leaders, but we have forgotten some things about leadership. It is time to remember. Our world—with its complexity and confusion—demands a course correction, now.

We can no longer afford to squander our talents and resources—globally, nationally, individually. We must get clear about this leadership business. It deserves everyone's attention. No one is exempt from caring about leadership, for no one is exempt from its impact.

It seems to me that there is not a lack of leadership among people today, as some have claimed. It does appear, however, that we have lost sight of the real meaning of leadership. We have carelessly come to call leader some who are not, while failing to acknowledge many who are. The imagemakers have taken over, feeding us style instead of substance. We confuse leadership with figureheads, popularity and fame. Leadership is not a commodity to be bought with campaign dollars and must not be equated with titles or roles.

Real leaders are those human beings who look at life with a higher prospective. It is their vision that enables them to go in advance of others, guiding and showing the way. They are people who pursue the larger good, fueled by idealism but not without common sense and pragmatism. They care about the long-term result, but not the short-term fix or easy gain.

Real leaders put aside the petty clamoring of their egos and listen to an inner voice that seeks the best—not just for the individual or party or company, but for humankind. They constantly ask: Will this lead to the highest good? How will others be affected? Is this fair?

Real leaders urge us forward and upward through their example, not confusing us with impossible promises.

They unite their words and actions. We are rewarded with a clarity and truthfulness that we trust.

Real leaders are not concerned with amassing followers, but focus their energy instead on maintaining a clear view of the next step. They know the right course of action draws its own support.

Real leaders do not allow the rationale of the intellect to silence the instincts and eloquence of the heart. They are in touch with simple truths. We are impelled to listen to them.

Leadership cannot be taught, although skills of leadership can. Leadership cannot be conferred. It does not come with a college degree or professional accomplishment. Leadership requires a state of mind and soul, acquired in the process of personal evolution. It demands a readiness of the person. Only then can it be encouraged and nurtured. It requires sacrifice, choice and commitment.

Each of us grapples daily with the pull of greed, security, fear and power. We choose the master we will serve. Leaders choose service to others and the larger world.

Who can do and be all of this? Historically, we have thought it possible for only a chosen few, an elite group. What an enormous burden for a tiny minority and an easy escape from responsibility for the rest of us. This approach will not work today. The job is too big for just a few.

We each need to become reacquainted with our ability to discern the truth. We need to start caring again, raising our lowered standards and setting our sights on ideals. We need to awaken the potential and power within each of us, resurrecting our own silenced leadership.

This means we must come to grips with what we want our lives to look like. It means knowing for what we stand. It requires us to choose our values and honor them. It means leading our lives instead of letting others lead us by default—unconsciously following the whims and dictates of others. It requires us to look within ourselves for answers. It means asking and receiving more of ourselves. Then, and only then will we begin to demand more from our president, our congressmen and women, and our business leader and others.

Some of us will lead governments and corporations. Some will lead families. Some will enlighten the world. Others will reach out to a neighbor or stranger. Whatever our sphere of influence we impact others. As a result, it seems to be that we must lead our lives with purpose, dignity, compassion, and grace. We must claim our birthright, make our mark. Through our actions, we will catalyze others. Real leaders will emerge everywhere. We will know that we are each leaders, among a world of leaders." ■

Excerpts of MMS Executive Briefs

Blues Hit on "Newest" Product

Blue Cross/Blue Shield of Massachusetts ran into widespread opposition—from the MMS, the Massachusetts Hospital Association, and state legislators—to their "newest" health insurance product earlier this week at a public hearing conducted by the Rate Setting Commission and the Division of Insurance. At the hearing, witnesses unanimously condemned the Blues *Exclusive Care* plan as anticompetitive, anticonsumer, and a thinly veiled attempt to bail out the Blues' financially troubled HMO operation.

Under *Exclusive Care*, the Blues would provide medical services through a BC/BS HMO, which would act as an Exclusive Provider Organization (EPO). Subscribers would probably not see any differences between HMOs and EPOs, but employers could save money by restricting employee insurance choices to the Blues' EPO and Master Health Plus, *MMS President Josepy O'Conner, M.D.*, testifying at the hearing, warned of the dangers from a marketing strategy that encouraged and rewarded employers for selecting insurance products that eliminated any competition. "We do not believe that it is in the public interest that everyone be reduced to a state of dependence on a single insurer," he said.

Seven members of the legislature's Joint Committee on Insurance also testified in opposition to the plan; the sole witness testifying in support of the plan was *Edward Dailey*, general counsel for Blue Cross/Blue Shield.

Special Commission turns to Blues' reimbursement

Physician reimbursement was the subject on November 29 as the third and last of the informational hearings on medical malpractice insurance was held in Boston. This hearing was devoted to the changes in physician reimbursement mandated by Chapter 351 and centered on physician reimbursement under Blue Shield. *John Larkin Thompson*, president of Blue Cross/Blue Shield, stated that Massachusetts physicians have historically charged less than their colleagues in other states, but refused to concede that Massachusetts Blue Shield, versus the Blues in other states, pays physicians less and charges consumers more for medical services. At the end of the hearing, Senator Linda Melconian called for a study of reimbursements under Blue Shield in other states for several common procedures.

Harvard Decision Makers Seminar held

A seminar on critical health policy issues travelled to MMS on December 1, as the Health decision makers Seminars program sponsored by the Harvard School of Public Health's Department of Health Policy and Management met at MMS headquarters. *Barry M. Manuel, M.D.*, MMS vice president and associate dean of the Boston University School of Medicine, was a panelist for the December 1 session, which focused on "Economic In-

centives for Cost-Effective Care: What Works and What Doesn't."

The five-part series, which began in November, was designed to bring together leaders from labor, business, health insurance, hospitals, and medicine to discuss important health issues via panels that consider a prepared set of questions about the topic under discussion. Seminar attendees who were invited to participate included MMS leaders; representatives from professional organizations, including the Massachusetts Association of HMOs, Mass. Hospital Association and Mass. Nurses Association; Boston teaching hospitals; and state government. Other seminar topics have included risk sharing, vertical integration, integrating the provider and underwriting functions into single organizations, and future realities of health manpower supply. The final seminar in the series was held on December 8.

AMA Delegates give qualified "OK" to RBRVS

On Tuesday, December 6, the AMA House of Delegates adopted the policy that the Harvard Resource-Based Relative Value Scale (RBRVS)—if expanded and refined—would be an acceptable basis for an indemnity-based Medicare payment system for physicians. The House, at its Interim Meeting in Dallas, Texas, also made specific recommendations on how the RBRVS should be expanded and refined; recommendations included restudy of specialty-specific data with technical problems, more intensive work on the physician visit component, the question of geographic differences, and many other areas. In adopting the Board of Trustees Report AA on the RBRVS, the House directed the Board to report back at the 1989 Annual Meeting on progress and further developments on the RBRVS.

AMA to HCFA: Fix carrier review or we'll sue

In an announcement to the AMA House of Delegates meeting this week, the AMA gave the *Health Care Financing Administration* (HCFA) a ten-day deadline to resolve problems physicians have had for the past year on enforcement of "medical necessity" regulations under Medicare. Thousands of physicians have been frustrated and angered nationwide because of "overzealous enforcement and premature issuance of claims denial letters" under the current carrier review procedures, said the AMA. Although the AMA has met several times with *William Roper, M.D., HCFA administrator*, who promised to curtail the claims development process and work with the profession on the problems, *AMA Executive Vice President James H. Sammons, M.D.* said that Roper's promises were insufficient. The AMA will sue before the end of the year, Sammons noted, if the HCFA does not follow through on its promises to change the claim review procedures.

continued

Channel 7 Special Highlights MMS

MMS President Joseph J. O'Connor, M.D., appeared on "The Doctor Drain," part of a one-hour health special that aired on WNEV-TV Monday, December 26, from 8:00-9:00 p.m. This edition of the station's *Health matters* programming, hosted by WNEV-TV's Alan Xenakis, M.D., will also cover the future of medicine, emergency room care, problem children, and depression. Viewers of the December 26 program were able to write to the station after the broadcast and receive a list of organizations mentioned in the special to contact for further information.

To Your Computers!

Thursday, December 15th, was the date to join the PC revolution as the Society's newest member service, *Computerize*, was launched at the MEDLINK training facility, 1430 Main Street, Waltham. With the *Computerize* program, MMS members can receive substantial discounts on personal computer hardware and software, and other PC services from Businessland, one of the largest business automation marketing companies in the United States.

Whether beginner, intermediate, or advanced user, physicians will find everything they need for the electronic age through the *Computerize* program including the most popular hardware, essential software packages, attractive sale and lease arrangements, and specially discounted supplies. And with *Computerize*, MMS members will also have a special option to purchase MMSNET service when they purchase PC equipment.

Get "online" and give "networking" a new meaning for your medical practice: *Computerize!* For more information contact the Department of Membership Services at MMS headquarters.

Bits and Pieces

All MMS members will receive new *CME pocket booklets* next month to help them track CME credits in the 1989 license renewal cycle; the booklets are a quick and easy way to account for Category 1 and 2 CME credits. Call the CME specialist, Department of Education and Communications, at MMS headquarters for more information.

MMS Testifies at new Special Commission Meeting

The MMS, at the first meeting of the Special Commission to Study Physician Shortage in Massachusetts on December 14 in Boston, pledged its full support for the Commission's work over the coming months. *Wil Lybrand, Ph.D., special assistant to the evp for health policy*, who testified before the Commission on behalf of the Society, reiterated the Society's strong conviction that adequate patient access to medical services, not the physician-to-patient ratio in Massachusetts, was the critical issue. He also described the Society's long-term database project with Abt Associates, noting that the Society was working towards creation of a Massachusetts "masterfile," similar to the AMA's Masterfile, with

demographic information on Massachusetts physicians. *Vincent Scardino*, project director at Abt Associates (contractor to MMS), described his firm's analysis of the board of Registration in Medicine database.

Members of the Commission, which is chaired by *Secretary Philip Johnston, Executive Office of Human Services*, include *Deborah Prothrow-Stith, M.D., commissioner of Public Health; Paula Gold, Secretary of Consumer Affairs; Elder Affairs Secretary Paul Lanzikos*; members of local Councils on Aging, legislators, and representatives of the Mass. Hospital Association and the MMS (*MMS Vice President Barry Manuel, M.D.*, represents the Society on the Commission).

In setting the agenda for the next meeting of the Commission on February 1 in Boston, Secretary Johnston asked for national statistics on physician supply, and invited representatives of Cape Cod and Western Massachusetts hospitals to attend and present information on access problems in their area.

Briefs from Legal

The Society is addressing issues concerning the disciplinary process of the Board of Registration in Medicine. At the invitation of consumer Affairs *Secretary Paula Gold*, the Society's legal counsel participated in a meeting in the Secretary's office at which a number of defense lawyers and the Society raised general and particular concerns with the disciplinary process. The meeting covered a broad range of subjects, including whether the Board should permit counsel to make oral argument for physician defendants when the physician is accorded the opportunity to address the Board directly.

Society Offers CPT-4 Books

Physicians can still obtain copies of the *1988 Current Procedural Terminology, 4th edition* (CPT-4) coding books, from the MMS. The books will help physicians in claims coding for both Medicare and Blue Shield (the Blues changed to a new coding system in November based on the CPT-4).

A limited number of books are available, at a cost of \$12.00 each (50 percent discount from list price) plus \$2.40 postage. Payment can be made by check or charged (Mastercard, Visa, or American Express) over the telephone. For more information, contact the Department of Education and Communications at MMS headquarters.

Bits and Pieces

On the media front: an "op-ed" article by *MMS President Joseph J. O'Connor, M.D.*, on the impact of the Deferred Premium Liability on physicians, was published prominently in the December 14 edition of the *Worcester Telegram*. The op-ed described the retroactive bills recently mailed to Massachusetts drivers for 1987 auto insurance, and then asked, "How would you feel if you opened your mail one day and found a bill for \$20,000

continued

Excerpts of MMS Executive Briefs

continued from previous page

(the average DPL for obstetricians and orthopedists in 1988)?" The op-ed is also set to appear in the *Lowell Sun* and the *Berkshire Eagle* in coming weeks.

Commission gets Report on Physician Numbers

At December's meeting of the Special Commission that will examine physician shortages in Massachusetts, the *Massachusetts Health Data Consortium (MHDC)* released its report of the database from the Board of Registration in Medicine. The Consortium, in a press release, called its report a "comprehensive statewide analysis of the physician supply in Massachusetts." MHDC *Executive Director Elliot Stone* characterized the Board's information as "the most accurate available." The MMS issued a release urging the Commission to focus on patient access to medical services as its central issue, cautioning that physician/population ratios should not be used as the sole indicator of access. Stories in the print and broadcast media were mixed on the report—the *Quincy Patriot Ledger* published an article on December 19 that pointed out real medical access problems on the South Shore, while some Greater Boston radio stations touted the report as the first-ever comprehensive study of physician numbers. WBZ radio noted that... "the study should put to rest debate on numbers of doctors practicing in Massachusetts.

According to the Consortium, there are 34 percent more physicians in clinical practice in Massachusetts today than in 1976, with the specialties of pediatrics, internal medicine, obstetrics, and psychiatry the most prevalent. The Consortium's report was paid for by Blue Cross and Blue Shield of Massachusetts. The Society is currently analyzing the Consortium's report for technical accuracy.

The MMS, through a contract with ABT Associates, continues to work on development of its Massachusetts Physician Master Data Base that is merging data from the Board of Registration's file, the AMA Master File of U.S. physicians, and the Society's membership file. In a letter to the editor of the *Boston Globe* on their coverage of the Commission meeting, *MMS President Joseph J. O'Connor, M.D.*, reiterated that the real problem is adequate patient access to medical services.

FYI on JUA Bills

The December 1988/January 1989 issue of the MMS newsletter contained comprehensive charts on the Deferred Premium Liability charges to physicians insured by the Joint Underwriting Association. The article provides charts on the DPL and regular 1988-89 premium, plus a chart showing the old and revised rate classifications. MMS members have asked for the telephone numbers of the JUA to discuss particular questions on their bills should contact the JUA directly at its 50 Staniford Street

address in Boston or by calling (617) 742-5070. The JUA offices will be relocating early in 1989, and members will be notified of the new address and telephone at that time.

Mass MDs help in Armenia Relief

Physicians from across Massachusetts have joined their colleagues nationwide in providing financial and medical assistance to survivors of the devastating earthquake in Soviet Armenia earlier this month. The MMS provided a donation to a local Armenian relief association, and encourages members to do likewise. Contributions can be sent to many organizations, among them the Armenian Relief Society Earthquake Fund, P.O. Box 409, Watertown, MA 02272. Because of the overwhelming worldwide response to the disaster, Society officials have begun turning away additional physician volunteers to Armenia unless they speak Armenian or Russian and provide highly specialized care. For more information, contact Carolann Najarian, M.D., Medical Outreach for Armenia, Inc., at (617) 259-0202.

Mass-Health Cards Introduced

At a recent meeting, members of the MMS Committee on Tax-Supported Medical Care received an update from Department of Public Welfare (DPW) staff on implementation of the new *MassHealth card* program for Medicaid and CommonHealth patients. The MassHealth card is a permanent, plastic, wallet-sized card that replaces the previous paper cards issued monthly to Medicaid, General Relief-Medical Assistance clients, and patients under the new CommonHealth program. Physicians can use the card to verify eligibility for these patients twenty-four hours a day, seven days a week via a touchtone telephone or point-of-sale device. More complete information on the MassHealth card is contained in the December/January issue of *MMS News*, or members can call the MassHealth helpline at 1-800-833-7582.

Bits and Pieces...

MassPRO, the Society's subsidiary that performs Medicare peer review in Massachusetts, has received clarification from the *Health Care Financing Administration* that a physician can now initial an attestation statement rather than using a full signature. A Medicare letter has been issued by MassPRO to hospitals explaining how this clarification will be implemented; for information contact MassPRO at 890-0011... *December 31* was the deadline for the federal government to receive physicians' decisions on participating in the Medicare program for 1989.

continued

SJC: MD in Hennessey case did not discriminate

In a decision handed down on December 27, the Massachusetts Supreme Judicial Court (SJC) ruled that a physician's decision not to participate in the Medicaid program does not discriminate against Medicaid recipients and does not constitute unfair or deceptive trade practice. The case, *Hennessey v. Berger*, involved ophthalmologist Robert Berger, M.D., of Springfield, who was sued for alleged nontreatment of a Medicaid recipient. Although most of the charges were dismissed at the trial stage, the count concerning nonenrollment in Medicaid and if it constituted discrimination was appealed to the SJC. The SJC, in its seven-page decision, agreed with Dr. Berger's position and the Medical Society's contention (in its *amicus brief*) that the physician's nonenrollment in Medicaid was not discriminatory, noting:

"An examination of Federal and State law indicates that a physician's participation in the Medicaid program is voluntary. The Medicaid program... is a cooperative program between the Federal and State governments which is intended to provide certain necessary medical services to individuals who cannot afford them... A State that decides to participate in the program must comply with the Federal statute and regulations... Federal law does not mandate physician participation... but instead seeks to attract physicians voluntarily by requiring that States offer adequate financial incentives."

The SJC, however, also noted that state law prohibits a Medicaid nonparticipating physician from refusing to treat a Medicaid recipient on the same terms as a privately paying patient, and further observed that the physician is to provide the same quality of care to all patients, regardless of the physician's status in the Medicaid program.

MMS Campaigns for Blood Donor Month

In his first letter to the members in 1989, *MMS President Joseph J. O'Connor, M.D.*, will urge Massachusetts physicians to participate in January's National Volunteer Blood Donor Month. Dr. O'Connor also pledges the Society's support for the event. MMS members are urged to donate blood themselves—and encourage healthy patients to do likewise—at one of eight American Red Cross donor centers in Massachusetts or at mobile blood drives that will be scheduled in January.

MMS DPL Credit Appeal argued

On January 5, MMS counsel argued before the SJC its appeal of the Insurance Commissioner's decision to reduce the amount of TDPL ("Total Deferred Premium Liability") credit which is subtracted from the IDPL ("Individual Deferred Premium Liability") which is due from physicians who withdraw from the JUA system and are not statutorily exempt (e.g. as a 65-year old retiree) from further DPL obligations. The argument focused on statutory construction and legislative intent, over which

the parties disagree. An SJC decision is expected in the coming months.

Smoking Report hits 25th Anniversary

January 11 marks the 25th anniversary of publication of the landmark report from the Surgeon General on the dangers of smoking, *Report of the Advisory Committee to the Surgeon General on Smoking and Health*. Even with an increased emphasis on the dangers of smoking, more than 53 million Americans smoke today, and more than 300,000 persons die from tobacco-related causes each year. Organized medicine, however, continues the fight against smoking and its related diseases. On December 6, the AMA adopted a resolution calling for continued support of campaigns against tobacco use to reduce premature death and disability in the United States. The MMS campaign against tobacco use also continues. Last year the Medical Society, directed by the Committee on Public Health, encouraged physicians to remove magazines with tobacco advertising from their offices. Campaign kits made available to primary care physicians contained a listing of magazines that do not accept tobacco advertising, and table-top display posters warning patients about tobacco advertising and encouraging them not to smoke. In 1989, the campaign will add "Do Not Smoke—The Evidence Is In On Tobacco!" stickers that can be applied to magazines with tobacco advertising. The Society will also be sending a letter to editors of Massachusetts newspapers asking them not to carry tobacco advertising, and members are being urged to write similar letters. Look for more on the MMS anti-tobacco campaign in the coming months. To obtain an anti-tobacco kit, contact the Department of Education and Communications at MMS headquarters.

Bits and Pieces...

Andrew Bodnar, M.D., chairman of the board of Registration in Medicine, was re-elected to that office on January 4 for a one-year term; he was also reappointed to a three-year term on the Board. Other Board officers elected were *Marianne Ego*, vice chairman and *Marianne Prout, M.D.*, secretary. ■

Distinctive Dining at Springfield's

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Mercy Hospital To Open New Weldon Center For Rehabilitation

Mercy Hospital is bringing the most current in rehabilitation medicine to the people of western Massachusetts. In March, Mercy will open the new Weldon Center for Rehabilitation, a comprehensive rehab complex that will provide area patients with services previously available only in Boston or Connecticut.

Expanding the services previously offered at Mercy's Regional Rehabilitation Center, the Weldon Center will provide needed treatment for patients suffering head or spinal cord injuries, neurological diseases, orthopedic injuries and strokes.

In 1985, the state conducted a study which indicated the need for more rehabilitation beds in central and western Massachusetts. In June of 1987, the state's Public Health Council approved 61 additional beds for Mercy's Regional Rehabilitation Center, increasing its total capacity to 90 rehabilitation beds.

The first phase of the expansion is nearing completion, adding 30 more beds to the center: 15 for head injured patients and 15 for spinal cord injured patients. The new unit is located in the hospital's Wing Building, where complete renovation of the fourth floor has created a modern, state-of-the-art facility.

The expansion of the physical facilities is surpassed by the expansion of programs and services for rehabilitation patients in western Massachusetts.

Brenda Adamovich, Ph.D., vice president of rehabilitation services, said, "With the expansion of the center, Mercy is now able to increase services to stroke patients, and allow specialized rehabilitation units for patients with

spinal cord injuries, head injuries, multiple traumatic injuries, and orthopedic problems." Other services, in place or planned, include pulmonary, cardiac, and pediatric rehabilitation, along with industrial and sports medicine.

When the expansion is complete, 15 beds for spinal injury, 30 for stroke, and 30 more that will accommodate patients from all three groups, plus orthopedic, pulmonary, and possibly cardiac patients.

The impact of the increased bed capacity for western Massachusetts is particularly beneficial for head and spinal cord injury patients. Many of these people now have to be referred to Boston or Connecticut.

To implement the increased services offered at the Weldon Center, additions to staff have been underway. Professionals in

all areas have been and continue to be added.

Growth is also occurring in three existing day programs: a day rehabilitation program for head injured persons, day rehabilitation programs for stroke patients, amputees and their families have been established. The response continued



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to these groups has been outstanding, demonstrating the needs which existed in the area.

Industrial medicine, sports medicine, vocational rehabilitation, pain and stress management, pulmonary rehabilitation, and cardiac rehabilitation are new programs on the agenda, to be offered on an outpatient basis.

In August of 1988, Mercy created a new program for children with rehabilitation needs which brings together the professionals from a broad range of disciplines to provide comprehensive, integrated treatment for these patients. It is the most comprehensive interdisciplinary rehabilitation program for children to be offered in western Massachusetts.

"Our pediatric rehabilitation team currently includes audiologists, speech and language pathologists, occupational and physical therapists, psychologists and social workers, and we will soon be adding vocational evaluators and vision service professionals," said Carole Tommasetti, the Weldon Center's director of Speech, Hearing, Language and Vision Services. Tommasetti directed the development of the new program and now supervises the team.

"We recognized there was a lack of unified, integrated rehabilitation services for children in our area," Tommasetti said. "There have been therapy options available for pediatric patients, and very young children born at risk for disabilities might have been evaluated by early intervention teams, but for children over three, the options were very limited."

Adamovich also indicated that studies have shown a great need for comprehensive services for the 0 to 5, school age, and adolescent children in our area.

Tommasetti said patients for the new pediatric program are children with physical or neurological impairment, cerebral palsy, congenital birth defects or behavioral problems. These conditions and others can cause language disorders and other developmental learning disabilities which are evaluated and treated, along with physical and sensory problems, by the pediatric rehabilitation team. "There aren't enough resources in this area for treating learning disabilities," Tommasetti said.

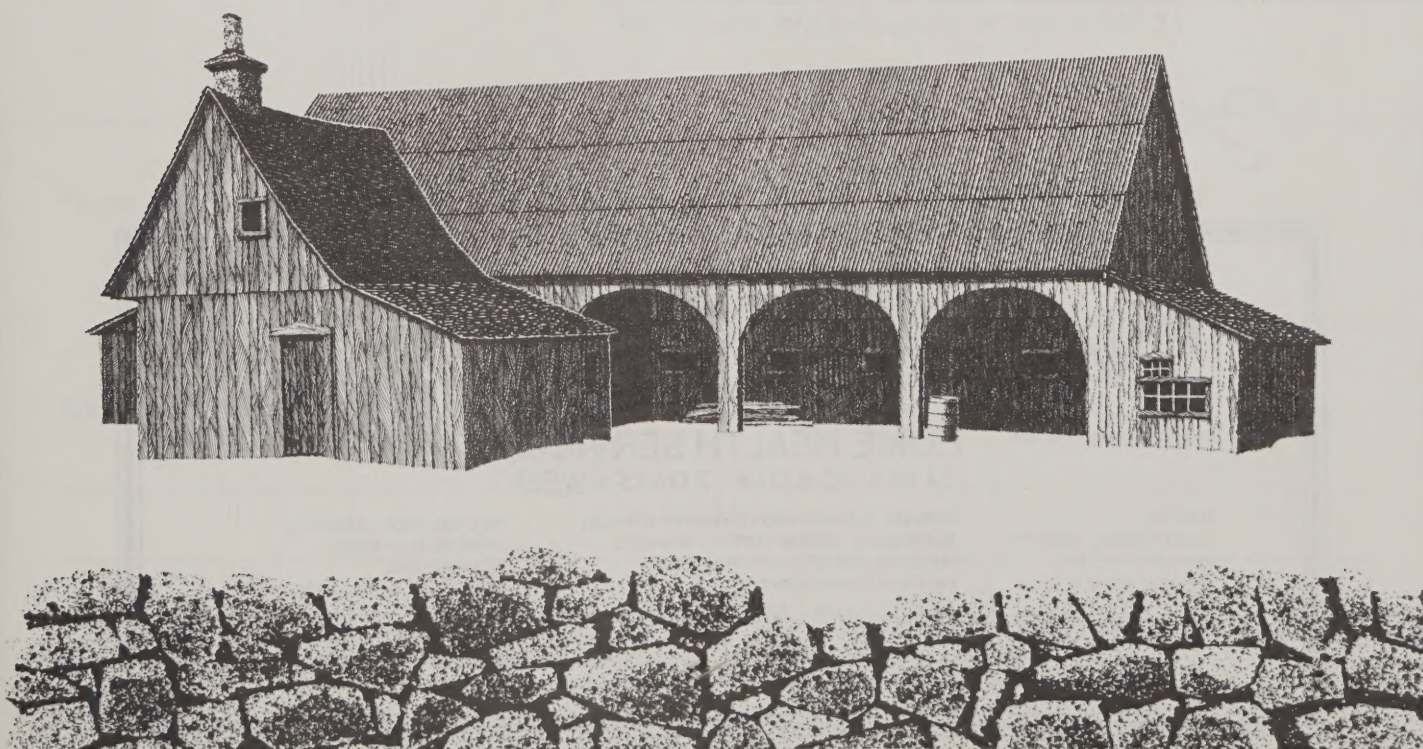
Recently, the Weldon Center received the maximum term of reaccreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF). The Day Rehabilitation program and general outpatient services have also been accredited by CARF for the first time. Both programs received the maximum three-year accreditation.

CARF is a national organization that serves as a "quality control intermediary" for the rehabilitation industry. Accreditation by CARF is considered essential for a program to be recognized as a quality rehabilitation service.

According to Adamovich, "CARF accreditation is one good way for consumers to evaluate our service. CARF accreditation tells consumers that we utilize highly qualified professionals to provide services and programs which are state of the art and of uniformly high quality."

Mercy Hospital, a member of the Springfield-based Providence Systems, has been providing rehabilitation services since 1972. ■

Ed Giganti
Giselle ten Hompel



Headlines

PRESIDENTIAL ADDRESS: *AMA President James E. Davis, M.D.*, recently urged physicians to "remain unified" on the resource-based relative value scale (RBRVS) issue. Speaking at the House of Delegates Interim Meeting in Dallas, Dr. Davis said the AMA is best qualified to navigate "The ship of medicine" through debates over the RBRVS. Dr. Davis also called registered care technologists "an idea whose time has come," noting the AMA's leadership in finding solutions to the nursing shortage.

LEGISLATION AND POLICY: *The AMA House of Delegates* has reaffirmed its support of an RBRVS but stopped short of endorsing the current Harvard study. In a report adopted during the Interim Meeting, the AMA outlined steps for expanding, correcting and refining the Harvard RBRVS... Tobacco industry sponsorship of sports events must be halted, AMA Trustee Lonnie R. Bristow, M.D., stressed in testimony before the Federal Interagency Committee on Smoking and Health. The AMA will press for enactment of HR 1272 prohibiting the sponsorship of athletic, artistic or other events under the brand name of a tobacco product... AMA President James E. Davis, M.D., has been appointed to the U.S. Bipartisan Commission on Comprehensive Health Care. The 15-member commission will examine shortcomings in the nation's health care delivery system and make recommendations to Health and Human Services.

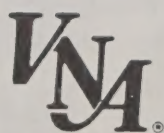
MEETINGS: Futurist Marvin Cetron will open the 1989 *National Leadership Conference* with an overview of "The New Environment of Medicine." Physician payment

systems, coverage for the uninsured, antitrust enforcement and risk management are among the topics scheduled for plenary and focus sessions. The AMA Division of Professional Relations coordinates the conference held February 24-26 in Chicago... The AMA Department of Biotechnology and Molecular Medicine will cosponsor the *Human Genome Conference* April 24-25 in Washington, DC. Discussion will focus on the scientific, technical and ethical issues involved in mapping the human genome.

PRODUCTS: All AMA members are now eligible for a free subscription to *AMA/NET*, the AMA-sponsored electronic information network. This service, provided by AMA subsidiary American Medical Computing Ltd., brings physicians instant access to a variety of on-line services... A step-by-step approach to counseling and education issues inherent in HIV antibody testing is now available in *HIV Blood Test Counseling: AMA Physician Guidelines*, a booklet produced by the AMA Division of Health Science.

PUBLIC RELATIONS: The 1989 edition of the *AMA Health Events Calendar* and an accompanying planning guide have been mailed to county, state and specialty medical societies. A limited number of calendars are available from the AMA Department of Consulting Services.

FOR FURTHER INFORMATION: For details on any products or services presented in this column, call the AMA, (312) 645-5000, and ask for the department mentioned in the news item. ■



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Pioneer Valley Defense Fund Trust Off To A Flying Start

Approximately 200 friends and supporters of the Springfield 24 gathered at the Sheraton Tara on Sunday, January 15, 1989, to celebrate the successful beginning of the Fund Raising Drive of the Pioneer Valley Defense Fund Trust. Besides the chance to meet old friends and enjoy tasty hors d'oeuvres, each participant donated \$75.00 towards the growing fund. A total of \$16,550 was raised at the reception.

As of Monday, January 16, 1989, it is said that the fund represents \$60,278 collected from near and far. There have been 107 donations locally and 202 from around the state and country. It has been variously estimated that the defense of these 24 physicians from the attack by our Attorney General Shannon could cost anywhere between \$500,000 and \$2,000,000 in legal fees. Thus, many more contributions are needed, but Sunday, January 15, 1989, was a good beginning. If you have yet to contribute, you may send your contribution along with the form shown below:



President Joseph O'Connor, M.D., under the T.V. lights of Channel 40.



Old Friends join in support of Springfield 24



Please send contribution to: **THE PIONEER VALLEY LEGAL DEFENSE FUND TRUST**
P.O. Box 61 ■ East Longmeadow, MA 01028

Amount \$ _____

Name and Address: _____

Please note that contributions or gifts to The Pioneer Valley Legal Defense Fund Trust are not deductible as charitable contributions for Federal income tax purposes.

Conference Announcement

For the fourth consecutive year, the Massachusetts Medical Society, the Massachusetts Veterinary Medical Association, Massachusetts Department of Public Health, and Tufts University School of Veterinary Medicine will co-sponsor a one-day conference on comparative aspects of infectious disease. This year's topic, "What is New in Parasitology? A Review for Veterinary and Medical Practitioners in New England" will be held *Wednesday, March 8, 1989* from 8:00 a.m.-4:45 p.m. at Bentley College in Waltham, MA. The conference will provide information to primary care physicians, veterinarians, infectious disease specialists and allied health professionals in the diagnosis, management and treatment of parasitic and arthropod borne diseases. There will be an emphasis on new developments in parasitology. This course has been approved for six hours of Category One credit of the Physician's Recognition Award of the AMA.

For additional information, please contact the Massachusetts Medical Society, Department of Education and Communications at (617) 893-4610. ■

Jackie Wagner,
Program Registrar

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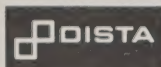
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Joint Commission Hospital Mental Health Standards Manuals Now Available

CHICAGO, December 15, 1988—The 1989 editions of the *Accreditation Manual for Hospitals (AMH)* and the *Consolidated Standards Manual (CSM)* are now available from the Joint Commission on Accreditation of Health-care Organizations.

The *AMH* incorporates a complete new and updated chapter on plant, technology and safety management and also includes:

- Revised standards on verification of practitioner credentials.
- New standards concerning appropriate discharge planning.
- New standards addressing risk management functions.
- Revised standards to foster increased and appropriate use of autopsies.

Revisions in the *CSM* acknowledge the realities and expectations of today's mental health services and organizations. These changes in the *CSM* include:

- Principles for child and adolescent services.
- A new chapter addressing services provided to mentally retarded and developmentally disabled persons.
- New and revised standards for alcohol and other drug dependence services.
- New standards for the development of do-not-resuscitate policies.
- Patient management standards that focus on the processes of admission, assessment, intervention, and discharge planning.
- Revised governing body, professional staff, and utilization review standards which reflect changes occurring in many organizations.

AMH standards are effective for accreditation survey beginning January 1, 1989. Standards in the *CSM* are effective July 1, 1989.

The *Accreditation Manual for Hospitals* can be purchased for \$60, and the *Consolidated Standards Manual* sells for \$40. To order, or for more information, contact the Joint Commission's customer service unit at (313) 642-6061, extension 650. ■

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Personal Finances

Life insurance, simply put, is insurance against loss of income due to death of bread earner. That is the critical factor to determine if one needs life insurance and, if yes, how much.

There are various measuring standards to determine the amount of necessary coverage, however all these standards do not take into account the individual customized needs.

Factors which determine the need and the amount of insurance include:

- (1) Annual amount of dollars needed to support life style desired by the family.
- (2) Dollars needed for various obligations: like children's education, debts etc.
- (3) Ages of both spouses.
- (4) Whether the spouse may go back to work.
- (5) Spouse's income.
- (6) Assets that are liquid or could be easily liquidated without undue loss of value or hardship to the family. For instance one may not count value of principle residence in calculating assets if the family does not want to move.
- (7) Other sources, like inheritance, etc.
- (8) Funds necessary in emergency (Usually 3 to 6 months of living expenses).

As one can see, no simple formula exists that can be applicable to everybody's needs. Furthermore, these factors are ever changing and thus the amount of insurance needs periodic evaluation and revision.

In general a younger physician needs more protection because he may have a young family, may have debts to pay off from the loans for medical school and start up of the practice. This leaves very little money for the purchase of the insurance protection he needs. As one gets older the amount of coverage needed decreases. In fact, if planned properly, there may not be any need for life insurance altogether in retirement years. After all one can retire only if they feel financially secure and do not need protection from loss of income. Older physicians may be told that they need to carry a large amount of insurance to have the liquidity to pay for the estate taxes due upon their death. For that good estate plan which will reduce the estate tax liability as much as possible is the first and absolute necessity and then only one should buy insurance if it is necessary.

What insurance should one buy? Term or whole life?

A younger physician should start with a term insurance which is the least expensive way to provide the amount of coverage he needs. With cash value policies your premium dollars buy far less insurance than they do with term policy. Reason being that the start up costs on cash value policies can be as much as 125%. In-

surance agent's commission including bonuses can be up to 110% in first two years. Also cash value builds up slowly in early years because the insurance companies take up to 15 years to take out this cost. Agent's commission on term policies is very small. Is it any wonder that one will hardly find an agent who sells term insurance? A good agent should first help determine the amount of coverage needed and then get as much of the coverage his client can afford, which, in the case of younger people, will be the term. Consumer oriented literature on this subject recommends term insurance as the best buy, because at this stage adequate coverage is the most important goal.

Agents emphasize tax deferred build up of the cash value. Returns on cash value policies are usually 2½ to 4%. One can beat that by purchasing the term and investing the difference even after paying the taxes on these investments with low income tax rates applicable now.

Term policies get more expensive as one gets older; however, the need for insurance also decreases. In fact in cash value policies as one accumulates more cash value the insurance protection decreases because face value of the policy payable upon death includes the cash values in the policy. In effect it becomes a decreasing term policy as far as the insurance protection is concerned. One can do that on his own. Also term insurances have become less and less expensive over a period of time because of intense competition.

If tax deferred build up of cash value is still very appealing one can buy a term policy with option to convert to one of the newer products of whole life, like universal life or variable life which will give an opportunity to buy whole life in later years when it is affordable, without requiring the physical examination. I will refer the readers to an article in MONEY magazine in December 1988 issue on this subject.

A word about Group term insurance available through various organizations. They are usually not a bargain for healthy persons because they usually lump all different risks together and thus if you are in good health you end up sharing the insurance company's risk of insuring bad risk people who otherwise can not get any insurance.

In conclusion when considering life insurance ask three important questions:

- (1) Do I need It?
- (2) How much coverage do I need?
- (3) What is the best choice in my case?

Because of changing circumstances one should evaluate his situation every 3 to 5 years and adjust the coverage accordingly. One may be able to purchase a less expensive policy if there are no health problems. ■

Gulabchand K. Shah, M.D.

Welcome New Members

Robert M. Austin, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: August 19, 1949
PREMED: Dartmouth College, NH 1967-71
MEDICAL: Boston University School of Medicine
1971-75
INTERNSHIP: Boston City Hospital 1975-76
RESIDENCY: University Hospital-Boston 1976-77
Tufts-N.E.M.C., Boston 1977-80
FELLOWSHIP: Tufts-N.E.M.C., Boston 1980-81
SPECIALTY: Radiology

John M. Joelson, M.D.
2 Medical Center Drive
Suite 410
Springfield, MA 01107

BORN: November 22, 1955
PREMED: Hamilton College, New York 1973-77
MEDICAL: Cornell University Medical College
1977-81
INTERNSHIP: Hartford Hospital 1981-82
RESIDENCY: Hartford Hospital 1982-84
FELLOWSHIP: Hartford Hospital 1984-85 Internal
Medicine 1985-88 Cardiology
SPECIALTY: Internal Medicine/Cardiology

Jose E. Llorens, M.D.
42 Ridgewood Terrace
Springfield, MA 01105

BORN: March 15, 1948
PREMED: Loyola University, Illinois 1967-71
MEDICAL: Universidad DeValencia, Spain 1971-81
INTERNSHIP: Baystate Medical Center 1981-82
RESIDENCY: Baystate Medical Center 1982-84
SPECIALTY: Pediatrics

Catherine E. O'Connor, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

BORN: June 8, 1963
PREMED: University of South Florida 1981-84
MEDICAL: University of South Florida College of
Medicine 1984/5-88
INTERNSHIP: Baystate Medical Center 7/88-Present
RESIDENT:

Cornelius A. Toner, M.D.
80 Congress Street
Springfield, MA 01104

BORN: May 1, 1933
PREMED: Bates College, Maine 1950-54
MEDICAL: Albany Medical College of Union Univ.
1954-58
INTERNSHIP: Maine Medical Center 1958-59
RESIDENCY: Maine Medical Center 1959-60
Tufts-New England Medical Center 1960-63
SPECIALTY: Neurology

Noble M. Hansen, Jr., M.D.
299 Carew Street
Springfield, MA 01104

BORN: March 9, 1945
PREMED: Dartmouth College, NH 1963-67
MEDICAL: Dartmouth Medical 1967-69
John Hopkins University 1969-71
INTERNSHIP: Johns Hopkins University Hospital 1971-72
RESIDENCY: John Hopkins University Hospital 1972-73
General Surgery
1973-78 Orthopedic Surgery
FELLOWSHIP: Institute Pathophysiology, Switzerland
1973-74
SPECIALTY: Orthopedic Surgery

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Hampden Committee Activities

There are less than usual committee activity over the holiday season, however the Executive Committee met on December 20, 1988. The meeting was highlighted by the following issues: an update on the Hampden Hippocrat confirmed the plan to expand the circulation of the Hampden Hippocrat with the February/March issue. It will be mailed to 1,700 physicians in Western Massachusetts and hopefully, from that issue on, will contribute to the "solidarity" of the physicians of this end of the state.

There was discussion of the size of the Hippocrat and it was agreed that the 28 page issue, 8½ x 11½ inch size would be retained.

There was discussion of a resolution concerning free choice of physician which was presented by Dr. Ryan for approval to be sent to the Mass. Medical Society. This was approved in principle with a plan that it would be reviewed by Senator Linda Melconian along with Drs. Terry Ryan and Gregory Schlacta for consideration of this political consequences.

Review of the 89-90 budget was the next issue. The two primary changes were in the Library Committee whose budget would be decreased by one-third from \$13,650 to \$9,100, and increased the Public Relations budget from \$3,000 to \$12,000. After discussion the budget was approved as presented by Dr. Remsburg. It will be published in a newsletter and brought before the members in the January 24, 1989, meeting.

There was an update on the "Defense Fund" under the leadership of Dr. Cahill. The fund is rapidly growing. Seven hundred and fifty invitations were mailed for a fund raiser that was held on January 15 at the Sheraton Tara and an additional mailing was made to the members of the Mass. Medical Society.

The January 24, 1989, District Meeting was discussed. In addition to speaking to our organization, Dr. Nelson of the AMA was scheduled to speak at a breakfast meeting at Sheraton West on January 25 and at the Kiwanis Club luncheon at Vallee's Steakhouse later that day. Several of the members of the Executive Committee will accompany him.

Plans for the Annual Meeting on April 11, 1989 were also discussed, but they are incomplete at this time.

There were no other HDMS committee meetings reported to the Hippocrat at the time of printing. ■

Terry D. Ryan, M.D.

IN MEMORIAM

EDWARD I. SWEET, M.D. 1938-1988

Dr. Edward I. Sweet died suddenly at home in Longmeadow, MA on December 21, 1988 at the age of 50. He was born in Providence, Rhode Island in July 1938, attended Brown University, graduating in 1960. He graduated from Tufts University Medical School in 1964, interned at University of Florida Teaching Hospital and Clinics, and did his residency in Diagnostic Radiology at Yale-New Haven Hospital from 1965-68. He then served in the Public Health Service at the National Institutes of Health in Bethesda, Maryland from 1968-70. He subsequently entered private practice of Radiology in Springfield, MA. He was on the staffs of Baystate Medical Center, Shriners Hospital for Crippled Children, Mercy Hospital in Springfield—also Wing Memorial Hospital in Palmer, MA and Ludlow (MA) Hospital.

Dr. Sweet was certified by the American Board of Radiology in 1969, was Chief of Radiology at Shriners Hospital, and was an Assistant Clinical Professor of Radiology at Tufts University. He was a member of numerous medical and radiologic societies, including American Medical Association, American College of Radiology, Massachusetts Medical Society, Hampden District Medical Society, Massachusetts Radiologic Society. He was an active supporter of Brown University, serving as Regional Director for the Board of Admissions for the past several years.

Ed had a deep commitment to his fellow man—be he patient, friend, peer or stranger. If there was a need, he was always unhesitatingly ready to help. It was not unusual to see him accompany a friend to the OR so he wouldn't be alone, or to see him at the hospital with an injured high school hockey or lacrosse player. His basic tenets were caring and dignity.

Ed was very much a family man, manifesting the same degree of intensity and devotion with them as he did with medicine. He is survived by his lovely wife Helaine, daughters Kimberly and Jennifer, and son Michael. He will be sorely missed by family, friends, and the medical community. ■

Gerald N. LaPierre, M.D.

Insurance Report

The Hampden District Medical Society has entered into an arrangement with the Monarch Life Insurance Company to make available Monarch products in disability and office overhead insurance to members of the Hampden District Medical Society at a substantial discount.

Monarch is one of the leading insurance companies in the area of disability insurance. In addition to that, they are local. We can expect excellent service from them.

This program is not intended to replace or be in competition with the disability and office overhead available through Lester Burdick, Inc. This program offers excellent insurance at very favorable rates. The Monarch program would be applicable to a physician who wished to obtain insurance in excess of the limits offered by Burdick, which at the present time are \$1500.00 per week for disability insurance. The insurance offered by Burdick is much less expensive and contains most of the features present in the individual plans offered by Monarch. The Hampden County Bar Association has a similar arrangement with both Burdick and Monarch. Members are urged to compare the details of insurance and price on these programs before making a decision should they consider increasing their coverage.

The Mass JUA has, without announcement, changed their policy concerning important aspects of medical malpractice insurance in Massachusetts.

Until approximately one year ago, physicians could be involved with procedures and activities in a higher category than that for which they were insured, provided that the higher risk activity did not involve more than 30% of their practice. This policy was changed at some time without notice. The policy now is that any higher risk activity will automatically result in the physician being rated in the higher class. This change is very important to general surgeons and certain other surgical specialist.

Apparently, the JUA is planning to institute this at the time of re-application for renewal of ones malpractice insurance. The implication is very important and physicians should have a clear understanding of this when filling out their renewal applications. It has been extremely difficult to obtain clarification of this policy from the JUA.

Physicians should be very careful in filling out their renewal application so as to be sure that they will be insured for the activities in which they are engaged.

It is anticipated that there will again be a very substantial increase in premiums for malpractice insurance for the year 1989-90. In addition, a merit rating program of some sort is supposed to be instituted in January of 1989. The method of determining who will be assessed a surcharge, how much, and on what basis has yet to be determined. A ruling from the insurance commissioner is tentatively scheduled for January of 1989.

Save your money folks!

Respectfully submitted,
Lorne C. Smith, M.D.

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Public health nurses of the Health Department hold FREE conferences to screen children before problems arise. Conferences are offered at community sites to Springfield residents, primarily targeting those without access to private health care. There are also plans to hold a conference at the Smith Center of the Springfield Health Department in the near future. Services offered to infants and pre-school children are physical exams, immunizations against childhood diseases, growth and development checks, tuberculin and lead testing, hematocrit, urinalysis, and blood pressure check. With childhood screening, problems are recognized at an early stage and are referred to a physician for treatment.

Mothers also receive help with parenting problems. Children's developmental stages are discussed so mothers will know what to expect as their children grow. Appointments are required for Well Child Conference. For more information or an appointment call 787-6736. ■

Laura Mullen,
Springfield Public Health Department

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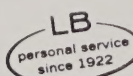
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